Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: December 21, 2023

Inspection Number: 2023-1072-0007

Inspection Type:
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Bayview, North York

Lead Inspector	**Inspector Digital Signature**
Lisa Salonen Mackay (000761)	Lisa A Salonen Mackay Digitally signed by Lisa A Salonen Mackay Date: 2024.01.02 06:41:06 -05'00'

Additional Inspector(s)
Kirthiga Ravindran (000760)
Christine Francis (740880), Training Specialist attended this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 13, 14, 18, 19, 2023

The following intake(s) were inspected:

- Intake: #00087446 / Critical Incident (CI) #2460-000012-23 - related to falls prevention and management
- Intake: #00100012 / CI #2460-000017-23 - related to falls prevention and management

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The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure the plan of care was revised when the resident's care set out in the plan was no longer necessary.

Rationale and Summary

According to resident's care plan, an intervention should have been in place as a fall's prevention intervention.

During an interview and observation, Registered Practical Nurse acknowledged this intervention was not in use. The Registered Nurse also confirmed this intervention was not necessary for the resident and therefore the care plan should match the resident's care needs.

The care plan was updated to discontinue this intervention as a falls prevention intervention for the resident.

Failure to update and revise the resident's plan of care put them at risk for not having the correct fall intervention.

Sources: Review of resident's clinical record, interview and observation with staff. [000761]

Date Remedy Implemented: December 19, 2023